Department of LABOR AND INDUSTRIES

Published by
Health Services Analysis Section
Olympia, WA 98504-4322

PROVIDER BULLETIN

PB 02-04

THIS ISSUE

Utilization Review Program New UR Firm

TO:

Medical Physicians
Osteopathic Physicians
Podiatric Physicians
Nurses & Nurse Practitioners
Physician Assistants
Clinics
Chiropractic Physicians
Naturopathic Physicians
Surgery Centers
Urgent Care Centers
Free Standing Emergency Care Centers
Third Party Administrators
Hospitals:
Please route to:
Utilization Review
Quality Assurance
Medical Records
Patient Accounts
Internal Auditing
Admitting
Case Management
Social Services

CONTACTS:

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Contract Manager for UR
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http://www.lni.wa.gov/hsa/hsa_pbs.htm

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Purpose

The purpose of this Provider Bulletin is to announce a change in the utilization review contractor. The Department has contracted with PRO-West. PRO-West will be providing utilization review services beginning May 1, 2002.

Program Description

The department's contracted Utilization Review (UR) program began on July 18, 1988. The program only applies to claims that are adjudicated by the State Fund. The UR program applies to both physicians and facilities. The department defines UR as the process of comparing requests for medical services ("utilization") to treatment guidelines that are deemed appropriate for such services, and includes the preparation of a recommendation based on that comparison. The office of the Medical Director (OMD) manages the contract with the department's UR vendor, and monitors the quality of reviews by the UR vendor. The goal of the UR program is to support the agency's mission to purchase only proper and necessary care for injured workers.

The department has entered into a contract with PRO-West to provide utilization review services. Reviews are initially conducted by PRO-West staff nurses, and may go on to their physician consultants for further review.

As a condition of the contract, PRO-West will review all the outpatient procedures listed in Table 1 of this bulletin. The department also requires PRO-West to review all inpatient hospital stays except: 1) treatment by contracted pain programs, 2) chemical dependency treatment, 3) head injury care in a sub-acute setting, or 4) care in a skilled nursing facility, transitional care unit, or step down unit. The department reviews these conditions internally for proper and necessary care.

PRO-West will use the Department's Medical Treatment Guidelines. The guidelines are available on the Internet at http://www.lni.wa.gov/hsa/hsa_pbs.htm or by calling the Office of the Medical Director (OMD) Publications line at (360) 902-5026.

PRO-West reviewers make recommendations only. They do not authorize or deny a procedure or service. This is the sole responsibility of the department's claim manager.

Definitions

Prospective Review
Prospective reviews are those conducted prior to the delivery of the services requested. Prospective reviews may be for inpatient or outpatient procedures or services.

Concurrent Review
Concurrent reviews are those performed while the worker is still an inpatient and services are being provided. Concurrent reviews can occur in one of three ways: 1) The timing of a review is planned to cover services as they are being provided (e.g. the need to extend a current hospitalization); or 2) During an emergency admission when a prospective review is not possible; or 3) When a provider or facility notifies the department of an admission for a non-emergent procedure and a prospective review was not performed.

Retrospective Review
Retrospective reviews are performed after the requested service or procedure has already occurred and the patient has been discharged.

Re-Review
A re-review occurs when a provider or claim manager requests that PRO-West take another look at their initial recommendation on a claim.

Protest, Reconsideration, and Appeal
When the claim manager decides to authorize or deny an inpatient admission or treatment, he or she will inform the provider of that decision by letter. The denial letter will include instructions about the provider's options to submit a protest or request for reconsideration to the department or to the Board of Industrial Insurance Appeals. The provider then has 60 days after receipt of the claim manager's letter to request in writing that the decision be reconsidered. If the provider wishes to protest the department's reconsideration decision the provider has another 60 days after receipt of that decision to appeal to the Board of Industrial Insurance appeals at 2430 Chandler Ct. S.W. Olympia, WA 98504-2401. If you have questions about this process, please contact the claim manager.

Pre-certification Number / Notification Number / Prior Authorization (PA) Number
These terms are often used interchangeably by different business groups. At L&I, they all refer to the 10 digit number that is issued by the UR vendor for each review they perform. The number is sometimes referred to as a "pre-certification number" by the vendor; a "notification number" by providers, and a "prior authorization number" if the claim manager authorizes or denies a procedure. Hospitals may use the term "reference number." These terms are all synonymous.

Important things to know about PA Number:
- Having a PA number assigned to your request does not guarantee the procedure or treatment will be authorized.
- Lack of a PA number on your bill may cause it to deny. Including the PA number on bills submitted to the department expedites their processing.
- Knowing the PA number will help you when inquiring about the status of the request.
- The PA number is used to track hospital and physician bills that are associated with a request. It can also be used to access information in the claim file.

Services that require Utilization Review

Inpatient
All inpatient hospitalizations require utilization review by PRO-West, with the exceptions listed previously. However, providers should not delay surgical intervention if delay will compromise a worker's health, safety or chance for a good surgical outcome. In the event of an emergency admission, providers should telephone PRO-West within 24 hours or on the first working day following admission.

Outpatient
The department does not require utilization review on all outpatient procedures. Only the procedures listed in Table 1 require review.

Table 1. List of Outpatient Procedures Requiring UR

DIAGNOSTIC ARTHROSCOPIES		
	CPT Procedure Codes (Non-Hospital Provider)	**ICD.9 Surgical Procedure Codes (Hospital Provider)**
Diagnostic arthroscopy of shoulder	29805	80.21
Diagnostic arthroscopy of elbow	29830	80.22
Diagnostic arthroscopy of wrist	29840	80.23
Diagnostic arthroscopy of knee	29870	80.26
Unlisted procedure arthroscopy	29999	80.20
SURGICAL ARTHROSCOPIES		
	CPT Procedure Codes (Non-Hospital Provider)	**ICD.9 Surgical procedure Codes (Hospital Provider)**
Shoulder	29805, 29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29826	80.21
Knee	29871, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886, 29887, 29888, 29889	80.26
SHOULDER SURGERIES		
	CPT Procedure Codes (Non-Hospital Provider)	**ICD.9 Surgical procedure Codes (Hospital Provider)**
Arthrotomies	23100, 23101, 23105 23106, 23107	80.11
Claviculectomies	23120, 23125 (partial/total)	77.81 77.91
Acromioplasty	23130	81.81 81.82 81.83
Ostectomy of the scapula	23190	77.81 (partial) 77.91 (total)
Rotator cuff repair	23410, 23412 (acute/chronic)	83.63

Repair of shoulder	23420	83.63
Coracoacromial ligament release	23415	83.63
Biceps tendon repair	23430, 24342	83.88
Biceps tendon resection	23440	83.42
Repair shoulder capsule	23450, 23460 23462, 23465, 23466	81.82 81.93
Bankart shoulder repair	23455	81.82
Open treatment dislocation	23550, 23552	81.82
Rib Resection for TOS	21600, 21615	77.81, 77.91
Unlisted procedure, shoulder	23929	81.83

NEUROPLASTIES

	CPT Procedure Codes (Non-Hospital Provider)	**ICD.9 Surgical procedure Codes (Hospital Provider)**
Revise ulnar nerve at elbow	64718	04.6 (transposition) 04.49 (release)
Revise ulnar nerve at wrist	64719	04.49
Carpal tunnel surgery	64721	04.43
Wrist endoscopy or surgery	29848	80.23

SPINE SURGERIES

	CPT Procedure Codes (Non-Hospital Provider)	**ICD.9 Surgical procedure Codes (Hospital Provider)**
Laminectomies/ Diskectomies	63001-63308	03.01, 03.02 03.09, 80.50 80.51, 80.59
Arthrodesis of spine	22548-22819	81.00, 81.01 81.02, 81.04 81.06
Exploration and Instrumentation	22830-22855	03.02, 81.05 78.69

What Providers and Staff need to know about the UR Process

Who to Contact for Questions about the Program, Contract, or Process

At Labor & Industries:

Associate Medical Director in charge of UR	Lee Glass MD	360-902-4256
Contract Manager	Nikki D'Urso, RN, Occupational Nurse Consultant	360-902-5034

At PRO-West:

UR Manager	Lori Rice, RN,CPUR,CCM	800-541-2894 206-366-3373
Medical Director	Fred M. Drennan, MD,MHA	206-364-9700

By Postal Service:
PRO-West
10700 Meridian Ave N, Suite 100
P.O. Box 33400
Seattle, Washington 98133-9075

By Phone or Fax:
Phone: 800-541-2894
206-366-3360
Fax: 877-665-0383 (toll free)
206-366-3378

Who to Contact for Questions about Specific Claims or Reviews

Providers can call the department's Interactive Voice Response (IVR) system at 1-800-831-5227 between the hours of 6:00am and 7:00pm weekdays, to obtain automated information regarding the status of a claim, authorized medical procedures, allowed diagnosis, a claim manager's name and phone number, and other claim specific information. For personal assistance, providers may contact the Provider Hotline at 1-800-848-0811 or the patient's claim manager.

How the UR Process Works

The department requires that physicians who wish to admit patients for inpatient hospital stays or who wish to perform selected outpatient procedures (see Table 1), request a review by PRO-West and obtain a subsequent authorization or denial decision by the department's claim manager. On the occasions where a facility admits patients without a prior review or authorization (e.g. on an emergency basis), the facility should contact PRO-West directly as soon as possible to initiate the review process.

Failure to comply with the UR process may result in delayed or denied payment. Each time PRO-West makes a recommendation to the department, the claim manager will determine whether to authorize or deny it. If the CM authorizes the procedure, he or she enters the prior authorization

number, the authorization status, and an authorized admission date span into the claimant's computerized records. Payment is contingent on the authorization status, date and code accuracy, and the injured worker's eligibility for coverage. This applies to both facility charges and professional charges that are associated with the given admission or procedure.

How to Request a Review

1. To request a review for an inpatient hospitalization or for an outpatient procedure that requires UR, contact PRO-West via the toll-free phone (1-**800-541-2894),** local phone, (206-366-3360) or toll-free fax **(1-877-665-0383)** numbers.
2. PRO-West review staff will be available by phone between the hours of 7:00 a.m. and 5:00 p.m. Pacific time. Providers can leave a phone or fax message requesting a review anytime during non-business hours and weekends.
3. Please be prepared to supply relevant clinical information to PRO-West with your request. This may include chart notes that document the patient's history, physical exam, diagnostic test results and the treatment plan. Refer to L&I's Medical Treatment Guidelines for information on what specific clinical information is required for selected procedures.

(Detailed step-by-step instructions on how to request a review are described at the end of this bulletin)

What PRO-West does with the Requests

1. Once PRO-West receives a request for a **prospective review** (see "Definitions" section) with all the necessary clinical information, they will assign it a "notification number" (same as department's PA number) and forward the case to their nurse for review. The nurse will compare the clinical information supplied by the requesting physician to either the department's treatment guidelines or other criteria.
2. PRO-West will perform a **concurrent review** (see "Definitions" section) if an authorized outpatient procedure extends into an inpatient stay. In these cases, the hospital or attending physician must notify PRO-West of the change in status so they can review the stay for the appropriate level of care.
3. PRO-West will perform a **retrospective review** (see "Definitions" section) in the same manner as a prospective review, only the patient will have already been discharged when the review begins.
4. PRO-West will notify the provider when they have completed a review. They will also inform the provider of the PA number and who to contact at the department for authorization.
5. If the clinical information supplied with the request does not meet the guidelines and/or criteria, the PRO-West review nurse will refer the request to a physician consultant for review. The physician consultant may call the requesting physician to discuss the request or to obtain additional information. Based on available information, the physician consultant will make a recommendation to the claim manager.

What the claims manager will do with the request

The claim manager will review the information and recommendation made by PRO-West and will then decide whether to authorize or deny the request. **The claim manager makes the final decision and is responsible for communicating that decision to the requesting provider.**

What to do if your Patient's Claim has not been Initiated
A worker's claim for benefits is considered to be "uninitiated" when the department has not received a completed and signed Report of Accident. RCW 51.48.060 requires physicians to file a report of accident with the department within five days of the treatment date. Reports of Accident may be faxed to the department at 360-902-4980.

PRO-West will review requests for treatment or procedures on uninitiated claims in the same manner as initiated claims. Physicians and facilities should follow the same UR procedure, but department authorization will be delayed until the claim has been initiated and assigned to a claim manager. Decisions for medical care should be based on the providers' best clinical judgment and not on the status of the request.

What to do if you have Additions or Changes to the CPT codes or Dates of Service on the Original Request
Please contact the Department, Office of the Medical Director by phone or fax as soon as possible if there are changes to the CPT codes or dates of service on the original request. If the request is for a CPT code change and the surgery has already occurred, please include a copy of the operative report. Please be aware that payment of your bill can be delayed if it's CPT codes and/or dates don't match your request. The phone and fax numbers are:
Phone: Liana Hunt, ONC 360-902-6377 or Darla Shaw 360-902-5028
Fax: 360-902-5600

What to do if you are not satisfied with the Outcome of your Request
First, identify *which* outcome you are not satisfied with:
a) If you are not satisfied with the outcome of PRO-West's recommendation, you can request directly from PRO-West that they re-review their recommendation. Be sure to include any new or additional information that would support the need for the requested procedure or treatment.
b) If you are not satisfied with the outcome of the claim manager's decision, you can either request that the claim manager reconsider the decision, or you can file an appeal directly with the Board of Industrial Insurance Appeals. Refer to either the "**Protest, Reconsideration and Appeal**" section above, or Labor & Industries' Attending Doctors' Handbook for more information on the protest and appeals process. The Attending Doctors' Handbook is available from your local Service Location or the department's warehouse at:

Department of Labor & Industries Warehouse
PO Box 44843
Olympia, WA 98504-4843

Step by Step Instructions on How to submit a Request for Review

Admitting physician or physician's staff:		1. Calls or faxes the request to PRO-West (1-800-541-2894) five or more calendar days before a planned elective admission or within 24 hours of an emergent admission. 2. Provides the following information to PRO-West: • Patient name • L&I claim number • Proposed or actual admission date • ICD-9-CM admitting diagnosis(es) • CPT codes for planned procedure(s) • L&I Provider number • Convenient time for the PRO-West nurse or physician consultant to call the physician back.
PRO-West intake staff:		3. Documents the information from the physician's office, assigns a notification number, and gives the information to a nurse to begin the review.
PRO-West nurse:		4. Compares documentation to L&I's medical treatment guidelines and/or other criteria 5. Evaluates the requested length of stay 6. Verifies CPT and ICD-9 codes are appropriate 7. Compares requested procedure with the accepted condition(s) on the patient's claim for benefits 8. If necessary, refers request to physician consultant or other appropriate physician reviewer 9. Informs physician's office when they have completed the review and have forwarded the recommendation to the department
PRO-West physician consultant:		10. If the review has been sent to physician consultant, he/she may contact the requesting physician directly to discuss the proposed treatment plan
L&I claim manager:		11. Reviews PRO-West's recommendation and makes decision to authorize or deny the request 12. Communicates his/her decision to the requesting physician 13. Enters appropriate information into L&I's computer system to insure appropriate payment
PRO-West nurse:		14. For unscheduled inpatient admissions, PRO-West will contact the physician to get the admission date. 15. For all inpatient admissions, verifies the admission and discharge dates, confirms actual procedure codes, and sends a final recommendation report to the claim manager

REQUEST FOR SURGERY FORM

INPATIENT / OUTPATIENT

(Please circle the appropriate one)

Patient Information

Name: _____Claim #: _____

Date of Birth:_____ Date of Injury: _____Social Security #:_____

Requesting Physician Information

Physician: _____L&I Provider #: _____

Office Contact: _____

Office Phone #: _____ Office Fax # :_____

Best time for PRO-West to contact the physician: _____

Procedure Information

Dates of Service: _____Requested Length of Stay: _____

Facility Name: _____L&I Provider #: _____

Facility Phone #:_____

ICD9-CM Diagnosis Code: _____CPT Code(s): _____

Indications for Surgery

_____

_____

_____

_____

_____

_____

Chart notes attached: Y / N (Please circle one) **Number of Pages:**

Please fax this form to
PRO-West **(877) 665-0383** or mail to:
10700 Meridian Ave. N, Suite 100
Seattle, Washington 98133-9075

WACs and RCWs

WAC 296-20-01002 Definitions (excerpt)

Proper and necessary:

(1) The department or self-insurer pays for proper and necessary health care services that are related to the diagnosis and treatment of an accepted condition.

(2) Under the Industrial Insurance Act, "proper and necessary" refers to those health care services which are:

  (a) Reflective of accepted standards of good practice, within the scope of practice of the provider's license or certification;

  (b) Curative or rehabilitative. Care must be of a type to cure the effects of a work-related injury or illness, or it must be rehabilitative. Curative treatment produces permanent changes, which eliminate or lessen the clinical effects of an accepted condition. Rehabilitative treatment allows an injured or ill worker to regain functional activity in the presence of an interfering accepted condition. Curative and rehabilitative care produce long-term changes;

  (c) Not delivered primarily for the convenience of the claimant, the claimant's attending doctor, or any other provider; and

  (d) Provided at the least cost and in the least intensive setting of care consistent with the other provisions of this definition.

(3) The department or self-insurer stops payment for health care services once a worker reaches a state of maximum medical improvement. Maximum medical improvement occurs when no fundamental or marked change in an accepted condition can be expected, with or without treatment. Maximum medical improvement may be present though there may be fluctuations in levels of pain and function. A worker's condition may have reached maximum medical improvement though it might be expected to improve or deteriorate with the passage of time. Once a worker's condition has reached maximum medical improvement, treatment that results only in temporary or transient changes is not proper and necessary. "Maximum medical improvement" is equivalent to "fixed and stable."

(4) In no case shall services which are inappropriate to the accepted condition or which present hazards in excess of the expected medical benefits be considered proper and necessary. Services that are controversial, obsolete, investigational or experimental are presumed not to be proper and necessary, and shall be authorized only as provided in WAC 296-20-03002(6) and 296-20-02850.

WAC 296-20-024 Utilization management

The department, as a trustee of the medical aid fund, has a duty to supervise the provision of proper and necessary medical care that is delivered promptly, efficiently, and economically. Toward this end, the department will institute programs of utilization management. These programs are designed to monitor and control the proper and necessary use and cost of, health care services. These programs include, but are not limited to, managed care contracting, prior authorization for services, and alternative reimbursement systems.

[Statutory Authority: RCW 51.04.020(4) and 51.04.030. 90-04-057, § 296-20-024, filed 2/2/90, effective 3/5/90; 87-24-050 (Order 87-23), § 296-20-024, filed 11/30/87, effective 1/1/88.]

WAC 296-20-075 Hospitalization

(1) Hospitalization will be paid for proper and necessary medical treatment of the accepted condition(s). The department may develop and implement utilization management criteria which will be used to review inpatient hospital admissions. Reimbursement for hospitalization is limited to proper and necessary care for an accepted condition. Failure to comply with these criteria may result in delayed or reduced reimbursement to the provider as allowed under chapter 51.48 RCW. Ward or semi-private accommodations will be paid, unless the worker's condition requires special care.

(2) Discharge from the hospital shall be at the earliest date possible consistent with proper health care. If transfer to a convalescent center or nursing home is indicated, prior arrangements should be made with the department or self-insurer. See WAC 296-20-091 for further information. The department may designate those diagnostic and surgical procedures which will be reimbursed only if performed in an outpatient setting. When procedures so designated must be performed in an inpatient setting for reasons of medical necessity, prior authorization must be obtained.

[Statutory Authority: RCW 51.04.020(4) and 51.04.030. 90-04-057, § 296-20-075, filed 2/2/90, effective 3/5/90; 87-24-050 (Order 87-23), § 296-20-075, filed 11/30/87, effective 1/1/88; 86-20-074 (Order 86-36), § 296-20-075, filed 10/1/86, effective 11/1/86; 86-06-032 (Order 86-19), § 296-20-075, filed 2/28/86, effective 4/1/86. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-075, filed 12/23/80, effective 3/1/81; Order 71-6, § 296-20-075, filed 6/1/71; Order 70-12, § 296-20-075, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-075, filed 11/27/68, effective 1/1/69.]